No. 95-1594

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Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

vs.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF CONNECTICUT, ET AL., AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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In The
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BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners

against

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents

On Writ Of Certiorari To The United States Court of Appeals For The Second Circuit

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BRIEF FOR THE STATES OF CONNECTICUT, et al. AS AMICI CURIAE IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST

The amici curiae states, through their attorneys general, respectfully submit this brief in support of Petitioners. Amici support reversal of the holding of the Second Circuit Court of Appeals, in *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 74 F.3d 28 (2d Cir. 1996), that New York's 0.6% Health Facility Assessment ("HFA"), as applied to an ERISA-owned and operated health facility, is preempted by ERISA.

The amici states have a strong interest in the ERISA preemption issues raised in this case. It is critical to the states that the scope of ERISA preemption be contained within its proper ambit so as not to interfere with the states' ability to regulate all providers of health care services, without regard to whether the health care provider is owned and operated by an ERISA plan.

This Court's decision in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Company*, 115 S. Ct. 1671 (1995)("Travelers") established that ERISA does not preempt state laws of general applicability that have the effect of increasing ERISA plan costs of purchasing health services for their participants and beneficiaries. Such economic impact, because it neither forces ERISA plans to adopt a certain scheme of substantive coverage nor restricts plans' choices of insurers, is insufficient to trigger ERISA preemption. Moreover, state laws of general applicability that regulate health care provider services, as opposed to core ERISA plan functions, should not be considered preempted when incidentally applied to health care providers owned and operated by ERISA plans.

In the case below, the Second Circuit held that, even when the effect of a state tax of general applicability was merely economic and did not restrict plan choices or activities, it was preempted because there was no third party

between the plan and the tax imposed. *NYSA-ILA*, 74 F.3d at 30. Based solely on the fact that the health facility was owned and operated by an ERISA plan, the Second Circuit held that New York's HFA, a state law of general applicability, was preempted as to this facility on the ground that the economic effect was "direct," with an immediate effect on the ERISA plan.

This reasoning depends on an artificial distinction that is inconsistent with the principles underlying this Court's decision in *Travelers*. As a practical matter, it also impinges on the states' ability to implement legislative solutions in areas of traditional state power. ERISA plans increasingly are choosing to provide health care and day care services to their participants and beneficiaries, rather than pay other entities to provide these services. ERISA plans are also property owners, consumers and employers that, up until now, have been subject to the same state taxes of general applicability as any other entity. In addition, new and complex forms of health care delivery systems are emerging that may be owned and operated, in whole or in part, by ERISA plans. The states' authority to tax and regulate all these entities and providers of service must not be limited by their identification as ERISA-owned and operated.

Furthermore, if ERISA-owned and operated health care facilities are exempt from the application of state health care related taxes enacted by states in accordance with federal Medicaid law, states will be precluded from obtaining the maximum federal matching funds. The states' efforts to assist hospitals with their uncompensated care costs will also be hampered if their health care related taxes are not applied to all health care facilities within a designated class.

The Second Circuit's adoption of the distinction between a direct economic effect (where there is no third party between the plan and the tax) and an indirect effect

(where the tax is on a third party and passed through to the plan) is thus of great concern to the amici states. It places the states on a slippery slope that ultimately threatens both to block appropriate state regulation of quality health care and interfere with states' efforts to initiate health care reform. States' regulation of health care and their general authority to tax must not be set by the organizational choices of ERISA plans. In fact, such a result would give ERISA plans an unintended and unwarranted competitive advantage in providing tax exempt and unregulated health care services.

SUMMARY OF ARGUMENT

The Second Circuit Court of Appeals erroneously concluded that a 0.6% state tax of general applicability, when imposed on a health facility owned and operated by an ERISA plan, is preempted by ERISA. The correct inquiry, under *Travelers*, is whether a state law operates in such a manner that it dictates or restricts an ERISA plan's benefit structure or administration. A law of general applicability that has a mere economic influence on an ERISA plan, whether directly or indirectly applied to an ERISA plan, is clearly not preempted. Nor should a law of general applicability that affects the operation of ERISA plans in their capacity as providers of health care services, as opposed to their capacity as ERISA plan administrators, be preempted.

States must not be precluded from exercising their traditional authority in the area of health care regulation in a uniform manner as to all health care providers that provide similar services. The Second Circuit's decision would prohibit regulation of plan-owned health care facilities, including requirements for licensure and compliance with health and environmental laws, since such regulation does ultimately impose costs on plan-owned facilities.

If plan-owned and operated facilities are exempt from state public health regulations, facilities that are not currently owned and operated by ERISA plans will look for a way to reorganize themselves to avoid such regulation. Similarly, more ERISA plans will choose to provide services themselves instead of funding the purchase of services. A large percentage of health care services, therefore, will become unregulated, a result contrary to sound public policy and which would threaten the health and safety of residents of the states.

As new forms of health care delivery arrangements emerge, states must have the flexibility and authority to regulate providers of services, regardless of whether the provider happens to be owned and operated by an ERISA plan. ERISA preempts state laws that impose obligations on the administrative practices of plans when they function as plans, not when they function as providers of services that are subject to generally applicable state laws.

Supreme Court precedent, in both *Travelers* and *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), supports a reversal of the Second Circuit's decision. This Court has held that the operation of a generally applicable statute, directly on ERISA plans, does not result in preemption, even though the burdens associated with the statute are imposed on the plans. In *Travelers*, this Court emphasized that if a state law of general applicability in the health care field does not mandate benefits, bind plan administrators to any particular choice, or preclude the uniform administrative practices of a plan, the law will not be preempted by ERISA. If ERISA plans choose to provide services that are the subject of traditional state regulation, it is critical that states have the authority to tax and regulate them as they would any other provider of services.

ARGUMENT

I. THE SECOND CIRCUIT'S PREEMPTION ANALYSIS IN *NYSA-ILA* THREATENS THE STATES' ABILITY TO PROTECT THE PUBLIC HEALTH AND WELFARE

As a result of *Travelers*, it is now firmly established that state laws regulating in the area of health care may have an economic effect on choices made by ERISA plans, without being preempted by ERISA. *Travelers*, 115 S. Ct at 1679. This Court reasoned that such economic influence "does not bind plan administrators to any particular choice and thus function as a regulation of the ERISA plan itself." *Id.* Significantly, the Court noted that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 115 S. Ct. at 1680. Yet the Second Circuit held that New York's HFA is invalid when an ERISA plan owns or operates a facility simply because, in such a case, the impact on the ERISA plan is "direct."[1/]

[1/] The Second Circuit's decision uses the term "direct economic impact" to distinguish it from what this Court referred to in *Travelers* as an "indirect" economic effect. We point out that the words "direct" and "indirect" appear to be terms of art that are not used consistently. For example, in *Travelers*, this Court referred to the economic effect on ERISA plans in *Mackey*, as "indirect," even though the garnishment statute in that case imposed administrative costs and burdens directly on the ERISA plans, without a third party between the plan and the garnishment. *See Travelers*, 115 S.Ct. at 1680. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981), this Court characterized a statute

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This rationale undermines this Court's holding that ERISA does not displace local health care regulation and spells disaster for the states.

A. States Will be Precluded from Regulating the Increasing Number of Facilities Owned and Operated by ERISA Plans.

Although the *NYSA-ILA* decision may be a case about the validity of a health care tax, ultimately at issue here is also the validity of public health regulations that are imposed uniformly on health care facilities, regardless of the ERISA-status of the owners and operators of the facilities. As with taxes, state public health regulations increase the cost of doing business for health care facilities. Consequently, if state tax laws are preempted as to ERISA-owned entities, state public health laws will also be preempted.

The employee benefits literature is replete with references to the trend toward employer-sponsored facilities

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that banned pension benefit offsets as having an "indirect" effect, even though it applied directly to a calculation technique. Similarly, in *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), the Second Circuit characterized a state escheat tax of general applicability as "indirect" despite the fact that the law required payment from and imposed costs on an ERISA plan. The use of the term "indirect" in these contexts appears to refer to the fact that the ERISA plans are neither singled out for imposition of the tax nor the intended target of the tax. The tax is levied on them incidentally through general application of the law.

offering services covered under employee benefit plans. *See, e.g.*, Louise Kertesz, *Employers, Insurers Center Attention on Primary Care*, Modern Healthcare, June 19, 1995 at 136. ("Employer and insurer-sponsored primary health care centers continue to multiply ... The business of providing directly contracted health care services to the business community is burgeoning..."); Jonathan Harris, *On Site Health Clinics*, The Self-Insurer, January 1995 at 7 ("[E]mployer-sponsored health care systems have gained in popularity as employers continue their attempts to control health care costs."); Deborah Cowans, *Interest in Employer-Sponsored Clinics Grows*, Business Insurance, February 21, 1994 at 3 ("[M]ore and more employees are taking the ultimate step in managed care: operating their own medical centers. . . . [H]ealth care management companies say that inquiries about forming new employer-sponsored health centers are streaming in."). In an attempt to cut costs and improve accessibility of health care to their employees, many companies, instead of self-insuring or funding benefits through the purchase of insurance, are offering health services themselves.

Similarly, many employers and ERISA plans are now operating on-site day care centers for their employees and their young children, instead of subsidizing the purchase of these services from other providers. They find that this arrangement results in increased productivity, improved employee morale, and more effective retention and recruitment of professionals. *See, e.g., On-Site Day Care for D.C. Law Firm Receives Favorable Verdict*, Employee Benefit News, February 1995 at 55; *How One Employer Implemented On-Site Child Care*, Employee Benefits Management Directions (CCH), July 11, 1995; Robert Kazel, *New York Life Sets Up Backup Care Center*, Business Insurance, November 13, 1995.

Legal services are another employee benefit that may be covered by ERISA plans. 29 U.S.C. § 1002(1)

(1988). Employer-sponsored, prepaid legal services are growing in popularity among large corporations and unions. Dick Dahl, *Lawyers Find Opportunity in Prepaid Legal Plans*, Lawyers Weekly USA, October 1993, at 1-11.

Under the Second Circuit's decision, if state regulations, which apply to all health care providers, all day care centers and all legal practices, are imposed on an ERISA plan by virtue of the ERISA plan's operation as a provider of services, the state regulations will be preempted. The consequences for the general public would be dramatic.

States, as part of their traditional functions, regulate health care facilities in an attempt to ensure at least a minimum of quality health care for their residents. For example, hospitals and nursing homes must meet specific licensure requirements that are essential to the protection of the public health. They are required, among other things, to maintain minimum standards for ratios of patients to registered nurses, infection control activities, sanitary conditions, dietary and laundry services and maintenance of medical records. *See, e.g.*, Ariz. Rev. Stat. Ann. §§ 36-401 to -431.01 (West 1993 & Supp. 1996); Conn. Gen. Stat. §19a-491 (1995); Fla. Stat. Ann. §§395.001, 395.1055 (West 1993 & Supp. 1996); N.H. Rev. Stat. Ann. §§151:1 to -:9 (1996); Texas Health & Safety Code Ann. §241.001 to -.029 (West 1992 & Supp. 1997); Conn. Agencies Regs. §19-13-D8t (1995); N.H. Code Admin. R. Ann. He-p 801.02 to 803.11 (1996). States also impose strict standards concerning the disposal of medical waste to protect patients, employees and the general public from unsanitary and dangerous conditions. *See, e.g.*, Cal. Health & Safety Code §§117600 - 118350 (Deering Special Pamphlet 1995); R.I. Gen. Laws §§23-19.12-1 to -19 (Supp. 1995); S.C. Code Ann. §§44-93-10 to -240 (Law. Co-op. Supp. 1995). It is clear, therefore, that, following the Second Circuit's reasoning in *NYSA-ILA*, a wide range of public health regulations would be preempted as to

ERISA-owned facilities because they increase the costs of operation of the facilities. As this Court noted in *Travelers*, 115 S.Ct at 1679, "[t]he bigger the package of regulation with indirect effects that would fall on [the ERISA plans'] reading of [the ERISA preemption clause], the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs."

States also regulate extensively the operation of all day care centers. They tend to be rigorous in their efforts to ensure that children will be cared for in a safe, healthy and nurturing environment, and that the staff that cares for the children has the necessary qualifications. *See e.g.*, Conn. Gen. Stat. §19a-80 (1995); Fla. Stat. Ann. §§402.302 to -.3125 (West 1993 & Supp. 1996); Wash. Rev. Code Ann. §§74.15.010 to -.200 (West 1982 & Supp. 1996); Conn. Agencies Regs. §§19a-79-1a to -12 (1993); Fla. Admin. Code Ann. r. 10M -12.001 to -12.014 (1995). Under *NYSA-ILA*, these laws, too, would be preempted. Similarly, for ERISA-owned and operated legal plans, the practice of law and lawyers who work for such plan-sponsored legal services would also be exempt from state statutes and regulations governing them and their practices. *See, e.g.*, Conn. Gen. Stat. §§51-80 to -88 (1995); N.H. Rev. Stat. Ann. §§311:1 to :13 (1995 & Supp. 1995); Okla. Stat. Ann. tit. 5 §§1 to 18 (West 1996 & Supp. 1997); Wis. Stat. Ann. §§757.293, -.295, -.30 (West 1981 & Supp. 1995).

As acknowledged in *Travelers*, state regulation, such as quality control and workplace regulation, will inevitably affect what an ERISA plan can afford or get for its money. *Travelers*, 115 S.Ct at 1679. Moreover, to the extent the regulated provider of services is owned and operated by an ERISA plan, the plan will argue that regulation of that provider is a "direct" effect on the plan itself and is therefore preempted. There is no evidence, however, that Congress intended that ERISA should be applied to prevent states from setting standards for the

quality of services rendered to residents in areas of traditional state regulation, merely because the service is provided by an ERISA benefit plan.

B. States Need Flexibility to Regulate Emerging and Innovative Forms of Health Care Delivery Systems

At issue also is the states' ability to regulate the delivery of health care services by new and sometimes complex business arrangements. States must retain the authority to protect the public concerning issues of access and quality of services. If an ERISA plan chooses to own and operate a health care provider network, this should not preclude the states from regulating it.

When ERISA was enacted in 1974, the health care industry was significantly different from what it is today. Health insurance was provided either through a traditional indemnity plan, or employers were self-insured. Karen Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-Emption*, 13 Yale J. on Reg. 255, 302 (1996) [hereinafter Jordan Article]. Congress had just enacted the Health Maintenance Organization ("HMO") Act of 1973, 42 U.S.C. § 300e (1994), in an attempt to contain costs and spur competition in the health care field.[2/] The ramifications of managed care[3/] and the use of provider networks,[4/] however, were

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[2/] Tom Christoffel, *Health and the Law* 148 (1982)

[3/] A broad definition of managed care encompasses the combination of health care financing and delivery functions within a single entity, focusing on cost and utilization control. The purpose of utilization review is

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not foreseeable at that time. Issues concerning participation in these networks and utilization review were not in the minds of lawmakers or policymakers.[5/] Congress could not possibly have contemplated that the ERISA preemption clause might be used to prevent states from exercising their traditional authority to regulate these new health care delivery arrangements.

Under managed care, instead of merely reviewing and paying for participants' health care, many HMOs, as providers of medical services, enter into contracts with provider groups or networks, or hire their own health care professionals to provide medical services. Shah Article, *supra* note 3 at 1550. ERISA plans, in turn, may enter into contracts with provider networks or with HMOs to provide health care services for their participants. In some cases, ERISA plans own and operate their own HMOs. Further, a third-party administrator with whom an employer may

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to ensure that patients receive only those medical services that are actually needed. Seema Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 Minn. L. Rev. 1545, 1548-9 (1996) [hereinafter Shah Article].

[4/] Provider networks are joint ventures among health care providers which are known by many names, such as provider-sponsored networks, integrated delivery systems or organized delivery systems. They are formed for the purpose of contracting with health care purchasers. Patricia Butler & Elizabeth Mitchell, *Health Care Provider Networks: Regulatory Issues for State Policy Makers* 1 (February 1996) (prepared for the National Academy for State Health Policy)

[5/] Jordan Article at 322.

contract may also be part of an integrated network and provide management services for the network.

In deciding whether a statute is preempted by ERISA, as impermissibly infringing on the "administration of the ERISA plan," courts must distinguish carefully between the practices that pertain to claims management, which are an integral part of ERISA plan operations, and practices that concern the network as a business or provider, which are not ERISA plan functions. *See generally* Jordan Article at 324-332 . State laws that interfere with the operation of ERISA plans' benefit and eligibility determinations should be preempted. State laws that affect ERISA plans in their capacity as medical services providers or as other business entities operating in the health care field, however, should not be preempted. *See Varity Corp. v. Howe*, 116 S.Ct. 1065, 1071 (1996) (recognizing that ERISA plans function in different capacities and that only certain ERISA plan activities involve plan administration or management and are subject to ERISA). *See also* Robert Pear, *HMO's Using Federal Law to Deflect Malpractice Suits*, N.Y. Times, November 17, 1996 at 24 (HMOs are arguing that they are protected from malpractice claims and lawsuits by ERISA). Although state laws that impose obligations on health care providers and businesses may result in increased costs to ERISA plans, they do not bind administrative decisions concerning core ERISA plan functions. Under *Travelers*, therefore, such state laws are valid as to all providers of services.

C. The States' Ability to Impose All Taxes of General Applicability Should Not Be Preempted

New York's HFA is imposed on all health centers as providers of care, not as ERISA plans. Imposition of the assessment has an economic effect that is applied to all

medical centers, without respect to whether they are operated by ERISA plans. The assessment, therefore, is purely economic in effect and is not targeted at ERISA plans. It has no direct relationship to the operation or administration of the ERISA plan itself. Pursuant to this Court's reasoning in *Travelers*, such a law clearly is not subject to ERISA preemption.

The power to tax is a traditional state function. Federal courts must give due respect to "the fundamental principle of comity between federal courts and state governments that is essential to 'Our Federalism,' particularly in the area of state taxation." *Fair Assessment in Real Estate Ass'n v. McNary*, 454 U.S. 100, 103 (1981). Without their ability to impose a wide variety of taxes for the purpose of raising revenues, states will be crippled in their efforts to provide all manner of services to their residents. ERISA should not be interpreted to interfere with states' general taxation authority, simply because there is an incidental economic effect on an ERISA plan. It is this principle that is clearly reflected in the *Travelers* decision.

In stark contrast to this principle, under the Second Circuit's reasoning in this case, state laws of general applicability, such as real estate taxes, sales taxes and unemployment taxes, if applied directly to an ERISA plan, would be preempted. An ERISA plan could potentially transfer real property within a state and avoid paying the same tax that all other property owners are responsible for paying. *See Morgan Guaranty Trust Co. v. Tax Appeals Tribunal*, 80 N.Y. 2d 44, 599 N.E. 2d 656 (1992) (pre-*Travelers* decision exempting an ERISA plan that owned and transferred property from payment of state real property transfer tax). Similarly, an ERISA plan with employees could also be exempt from paying state unemployment taxes for its employees and could avoid paying state sales taxes for its purchases of goods and services. Such an untenable result was not intended by

Congress when it enacted ERISA's preemption clause. *See Travelers*, 115 S.Ct. at 1677, 1683 (concluding from legislative history and from language in *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 142 (1990) that Congress intended to eliminate conflicting or inconsistent state regulations of employee benefit plans, not eliminate state laws in areas traditionally subject to local regulation). The HFA is entirely neutral, applying to all hospitals and health care providers in New York, not just those operated by ERISA plans. As the Second Circuit noted in *Rebaldo v. Cuomo*, 749 F.2d 133, 138,139 (2d Cir.), *cert. denied*, 472 U.S. 1008 (1985), Congress did not intend to permit ERISA plans to live a "charmed existence." ERISA plans must not be permitted to operate in a "fully insulated legal world" that exempts them from state laws of general applicability that only incidentally affect them.

D. The States Will Be Hampered in Their Efforts to Generate Funding Through Federally Authorized Health Care Related Taxes

Certain state taxes, in addition to being imposed pursuant to the states' general taxing authority, are also specifically recognized by Congress as a legitimate exercise of that authority. Federal Medicaid[6/] law explicitly

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[6/] Medicaid is a program of "cooperative federalism," whereby the cost of providing "medical assistance" is shared by the state and federal governments. Federal law sets forth the requirements that must be met by states as candidates for receiving partial federal financial participation for the cost of the program. 42 U.S.C. §

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acknowledges that states may apply their existing, standard taxes, such as sales taxes, to the provision of health care services. 42 U.S.C. §1396a(t) (1994). In addition, Congress specifically authorized health care provider taxes, 42 U.S.C. §1396b(w)(3) (1994), as a means for states to raise revenues. Many states have enacted one or both of these taxes.[7/]

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1396a (1994).

[7/] *See* Ala. Code § 40-26B-21 (Michie, WESTLAW through 1996 2d Sp. Sess.) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263b, as amended by Pub. Act 96-144 (West, WESTLAW through 1996 Reg. Sess.) (tax on "hospital gross earnings of each hospital"); Fla. Stat. Ann. § 395.7015 (West, WESTLAW through 1995 1st Reg. Sess.) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (Michie, WESTLAW through 1996 Reg. Sess.) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Comp. Stat. Ann. § 5/5A-2 (West's Smith-Hurd, WESTLAW through P.A. 89-505, apv. 6/28/96) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Banks-Baldwin, WESTLAW through end of 1995 3d Ex. Sess.) (2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. Ann. tit. 22, § 391 (West, WESTLAW through 1995 First Reg. Sess.) (assessment of 0.15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118 F, §15 (Law. Co-op. 1994 &

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Supp. 1996) (hospital assessments); Minn. Stat. § 256.9657 (West, WESTLAW through 1996 Reg. Sess.) (assessment on hospital revenues, nursing home beds and HMOs); Miss. Code Ann. § 43-13-145 (WESTLAW through 1995 Reg. Sess.) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (West, WESTLAW through 1995 1st Reg. Sess.) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (WESTLAW through 1995 Reg. Sess.) ($2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (WESTLAW through 1995 Reg. Sess., ch. 309, apv. 7/3/95) (Medicaid Enhancement Tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); N.Y. Pub. Health Law § 2807-a (23) - (27) (McKinney 1993 and Supp. 1996) (assessment on hospital revenues); R.I. Gen. Laws § 44-51-3 (Michie, WESTLAW through 1995 Reg. Sess.) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (WESTLAW through 1995 Reg. Sess.)(hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216(d) (WESTLAW through 1996 2d Reg. Sess.) (annual nursing home tax); Utah Code Ann. § 26-36-105 (Michie, WESTLAW through 1996 2d Sp. Sess.) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals' "audited gross inpatient revenues"); Vt. Stat. Ann. tit. 33 §§ 1950-1958 (Supp. 1996); W.Va. Code §§ 11-27-9,

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In most of these states, the revenue raised through these taxes is used by the state to make disproportionate share hospital ("DSH") payments to hospitals. 42 U.S.C. § 1396r-4 (1994). These payments help hospitals cover the costs of providing care to patients who are either uninsured or underinsured, and whose care would be provided by hospitals as uncompensated care. For inner-city hospitals with extremely high levels of uncompensated care, these DSH payments may make the difference between bankruptcy and survival. The same is true in rural Appalachian areas. Thus, it is economically depressed areas that would suffer most if DSH payments to hospitals must be reduced or eliminated.

A health care related tax is defined as "a tax . . . that -- is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services." 42 U.S.C. § 1396b(w)(3)(A)(i) (1994). Contemplated health care related taxes include "taxes based on revenues or receipts." 42 U.S.C. § 1396b(w)(3)(C)(i)(III) (1994). In order to be a qualifying health care related tax, the tax must meet specified criteria; one of these is that the tax must be imposed *uniformly* with respect to a class of providers of services. *Id.* In-patient hospital services, out-patient hospital services, nursing facility services, and services of health maintenance organizations are examples of "classes" of providers. 42 U.S.C. § 1396b(w)(7)(A) (1994).

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11-27-15 (Michie, WESTLAW through 1996 Reg. Sess.) (health care provider tax of 2.5% of gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. Ann. § 50.14 (West Supp. 1995) (assessment on "occupied, licensed beds" of nursing home facilities).

If ERISA preemption is construed to invalidate health care related taxes as applied to ERISA-owned and operated providers of a class of health care services, merely because a health care provider is an ERISA plan, a state's health care related tax will no longer be "uniform" and "broad-based." Federal law provides that if a state's health care related tax is not broad-based, the total amount expended by the state through its Medicaid program as "medical assistance," which would normally be matched by the federal government, is reduced by the sum of the revenues obtained from the health care related tax. 42 U.S. C. § 1396b(w) (1994). Consequently, if ERISA-owned facilities are exempt from the taxes, the result could be a loss of federal matching funds to the states. The impact will be greatest in the poorer states, i.e., those states that have low per capita incomes, and are least able to meet the health care needs of their residents. These states have higher "federal medical assistance percentages" and thus will suffer disproportionately from the impact of this decision. *See* 42 U.S.C.§ 1396d(b) (1994).

Moreover, for the states that use the revenue from their health care related taxes to make DSH payments to hospitals, which also qualify for matching federal funds, there are losses on two levels: first, less revenue is raised and redistributed to the hospitals because ERISA-owned entities are exempt from the taxes; second, the states are eligible for fewer matching dollars because the DSH payments will not be as great.

It defies logic that Congress would enact specific criteria that, if met, provide the states with an effective way to raise revenue and assist hospitals with their uncompensated care costs, and that ERISA would operate to make it impossible for the states to take advantage of that provision. ERISA should be interpreted to be consistent with other federal law. *See Travelers*, 115 S.Ct. at 1682 (ERISA's preemption clause should not be interpreted so

broadly as to render another federal law, enacted after ERISA, "utterly nugatory."). *See also* 29 U.S.C. § 1144(d) (1988) (ERISA shall not be construed to invalidate or impair the operation of any other federal law).

II. THE SECOND CIRCUIT'S ANALYSIS IN *NYSA-ILA* IS INCONSISTENT WITH THIS COURT'S DECISIONS IN *MACKEY* AND *TRAVELERS*

The *Travelers* decision clarified that this Court was unwilling to apply an unduly broad ERISA preemption analysis to state laws of general applicability in the health care area simply because of the ambiguity of the "relate to" language in ERISA. Rather, this Court understood the need to go beyond the language in ERISA and look to the objectives of the ERISA statute "as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 115 S. Ct at 1677.

> [W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress did not intend to supplant state law (citation omitted). Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, see *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719, 105 S.Ct 2371, 2378 . . . (1985), we have worked on the "assumption that historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress."

Travelers, 115 S.Ct at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). It is true that the precise holding in *Travelers* addresses the validity of a hospital surcharge that had only an "indirect" economic effect on ERISA plans, i.e., the tax was imposed on patient charges that were potentially paid by ERISA plans. Yet the *Travelers* decision does not imply that its result would have been any different if the taxes at issue had been imposed on the ERISA plan itself as part of the uniform application of a law of general applicability. The sole basis for the Second Circuit's decision that the HFA is preempted by ERISA in this case is that the state tax of general applicability, when applied to a plan-owned and operated facility, operates "directly" on the ERISA plan.[8/] *NYSA-ILA*, 74 F.3d at 30 ("[T]here is no third party between the plan and the tax imposed pursuant to the HFA"). There is no basis in law for this conclusion.

8/ It could be argued that the Court should have found that the HFA had only an indirect economic effect on the ERISA plan because the HFA is a direct tax on health care facilities and not on ERISA plans. *See* Walter Schuler, Note, *The ERISA Pre-Emption Narrows: Analysis of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company and Its Impact on State Regulation of Health Care*, 40 St. Louis Univ. L.J. 783, 815-822 (1996). A health care facility owned by an ERISA plan is not a benefit plan. The state regulation does not affect the ERISA plan's administration or benefits.

In *Travelers*, this Court set forth a clear standard by which to evaluate whether surcharges on patient charges and on HMOs[9/] are preempted by ERISA:

> An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the cost of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

Travelers, 115 S.Ct at 1679. *See supra* note 1 regarding use of the word "indirect."

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court upheld the application of a general state garnishment statute to ERISA plan participants' benefits that were in the hands of the ERISA plan. Plan trustees were required to respond to a summons and deposit the demanded funds that were due to

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9/ One of the surcharges approved in *Travelers* was a tax on HMOs, which could run as high as 9% of the aggregate monthly charges paid by HMOs for their members' inpatient hospital care. There was no discussion in *Travelers* of whether the HMOs were owned and operated by ERISA plans.

the debtor. These were funds that the trustees were otherwise required to hold and pay out to participants and beneficiaries. "At the very least, petitioners contend, plans subjected to garnishment will incur substantial administrative burdens and costs." *Mackey*, 486 U.S. at 831.

Accepting that such administrative burdens and costs to the plan may be present, this Court nevertheless ruled that the general garnishment statute was not preempted by ERISA: "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Mackey*, 486 U.S. at 831-32. *See also Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996), *application for cert. filed*, 64 U.S.L.W. 3808 (U.S. May 23, 1996) (No. 95-1913) (Relying extensively on *Mackey*, 2.35% tax on businesses not preempted by ERISA, even though the tax base included employers' payments to employee benefit plans); *Retirement Fund Trust of the Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266 (9th Cir. 1990) (California's general tax levy and withholding procedures not preempted as to ERISA plans); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.) ("Connecticut's escheat law has both an economic and administrative impact on ERISA plans. Aetna will have to pay all unclaimed benefits to the State . . . [and] make administrative and accounting adjustments to comply with the law. . . . These *indirect* economic and administrative effects were not substantial enough, however, to persuade us that this is the type of law Congress intended to preempt."), *cert. denied*, 493 U.S. 811 (1989) (emphasis added); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (upheld a generally applicable 2% municipal tax on income, even when that income was contributed by employees to their ERISA benefit plans because it "affect[ed] Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan.")

If ERISA plans do not want to pay the HFA directly, they can make a decision to offer their health benefits in a different way. "It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *Travelers*, 115 S.Ct at 1679. The HFA does not bind the plan to a particular choice, thereby regulating the plan. As demonstrated in *Mackey* and *Aetna Life*, the "direct" application of a state statute of general applicability to an ERISA plan, without affecting the primary operation and administrative function, such as eligibility for and amount of benefits, does not mean that the state statute is automatically preempted. *See Mackey*, 486 U.S. at 831-32; *Aetna Life*, 869 F.2d at 146-48. Particularly in this case, where the ERISA plan is functioning as a provider of medical services, even a "direct" effect on the ERISA plan should not be enough to preempt the state law because the impact is on the ERISA plan as a provider and not on its operations as an ERISA plan. *See Varity Corp.*, 116 S. Ct. at 1071 (recognizing that not all ERISA plan activities involve ERISA plan administration).

In *NYSA-ILA*, the ERISA plan decided to own and operate a medical clinic that was subject to the 0.6% HFA. If the ERISA plan had purchased insurance and paid the bill for its participant or beneficiary, it would have paid the HFA as part of patients' charges, a result clearly permissible under *Travelers*. Whether the ERISA plan pays the HFA in its function as a medical services provider or as an ERISA plan payer, the HFA does not force the ERISA plan to adopt a certain scheme of substantive coverage. The Second Circuit's decision in *NYSA-ILA* is inconsistent with Supreme Court precedent and should be reversed.

CONCLUSION

For the foregoing reasons, the decision of the Second Circuit Court of Appeals should be reversed.

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